patient in VA. Almost 84.2 million outpatient visits last year, 577,000 hospital discharges, 146 million prescriptions that were filled, and 727,000 patients receiving care via telehealth.

We're very proud of our VA workforce. VA is one of the largest civilian employers in the federal government and one of the largest healthcare employers in the world. As you can see on the screen, we have 327,000-plus total VHA employees, about a third of which, about 30 percent of which are veterans serving veterans.

We are one of the largest employers of physicians in the world with 25,000 employed physicians, and we have over 95,000 employed nursing personnel, Registered Nurses, nurse practitioners, Certified Registered Nurse Anesthetists, LPNs, and Certified Nursing Assistants.

As I mentioned earlier, we have identified both core services and foundational services. This is a list that is a menu that

you might see at any healthcare system across the country. There's a couple of the services here that are our core services that I just want to mention.

Care management has become increasingly important, as our veterans have options for aspects of their care, and as we continue to partner more robustly with our community and other federal agencies. Coordinating that care and ensure we capture every episode of care in a single health record will be a continuing challenge as we move forward with our modernization efforts.

The other core health service that I want to mention -- and I know that you'll be hearing more about the mental health aspects of our core services in a little bit -- but women's healthcare is another area to highlight. Women currently make up 10 percent of the veteran population in the U.S., and nearly half of that population is of reproductive age. It is the largest or

fastest-growing subgroup of our veteran population, so one that we feel as though we need to pay close attention to, to ensure we meet the needs of that veteran population, particularly when it comes to women veterans who are seeking assistance with fertility issues and maternity care.

Our foundational services are services that VA provides that the private sector may not. These are specialized healthcare services that are uniquely related to veterans' healthcare needs and veterans' healthcare experiences. And these are really some of the areas where I think VA really shines and sets our self apart as a national agency. There's a couple that I would like to highlight for you.

One of which is the Blind Rehab Services. We have a hub-and-spoke approach to providing blind rehabilitation with 13 hub sites nationally. This is a residential program that assists veterans with various

levels of loss of sight and assists them in developing successful strategies to ensure that they are safe in their daily life.

Veterans come as residents and they receive coaching in everything from managing money to navigating indoor and outdoor spaces, traveling, cooking, work on the computer, managing a new iPhone, and various arts and crafts, such as woodworking.

And the facility that I most recently worked at, we did have a blind rehab program, and to watch some of the veterans enjoy woodworking and using a circular saw without vision is really something to watch. But this is the type of coaching and services that blind rehab provides.

Environmental exposure is another area of work that VA provides that's unique to our healthcare system. Our veterans are exposed to agents depending on when and where they served, from Agent Orange to exposure related to burn pits. The VHA is attuned to

these unique exposures and monitors patients for healthcare issues related to such.

Our prosthetics and sensory aids is another area in which we really believe that we shine. This is a service that provides everything from service dogs to robotic arms, from low-vision devices, as I just mentioned in the blind rehab programs, to exoskeletons for our spinal cord injury and disease patients; wheelchairs and crutches. Our VHA prosthetic service covers a wide array of devices helping veterans to live full lives that maximize their mobility and their function.

And finally, I would like to highlight our spinal cord injury and disease program. We have 24 spinal cord injury and disease centers around the country, again, a hub-and-spoke approach to connect veterans with the care and the specialists that they need. We provide them annual physicals. We help veterans with acute injuries as well as chronic injuries, and have very full and detailed

programs, again, to help them navigate with their injury and be as mobile as they wish to be.

Finally, connected health. VA is aligning virtual care technologies to create a unified experience for veterans across all VA patient-facing technologies. Again, this links up with the VA priority of modernization, and there's a few of the virtual care technologies that we have listed here.

The clinical video telehealth is a telehealth service that uses health informatics, disease management, and telehealth technologies to target care and case management to improve access to care and improving the health of our veterans. Telehealth changes the location where healthcare services are routinely provided and, again, gets it close to the veterans or in the veteran's home.

Home telehealth actually uses devices that are placed in the home using phone lines or modems. That helps patients and their

care providers monitor chronic conditions such as congestive heart failure and diabetes and supports patients managing those diseases as they stay within the comfort of their home.

Store and forward telehealth is a technology used primarily in dermatology, radiology, and for the treatment of diabetic retinopathy. This telehealth technology involves the acquisition and storing of clinical information, be it data, images, sounds, or videos, that's then forwarded to or retrieved to by another site for clinical comparison and evaluation in the treatment of veterans.

Our tele-mental health leverages the expert mental health providers that may not otherwise be available locally to the veteran. We're doing more in telehealth than any other healthcare system and connecting mental health providers to areas where mental health providers are difficult to recruit or this area of healthcare may not be available. It is a

key priority for our tele-mental health services.

Mobile health. Mobile health aims to improve health of veterans by providing technologies that expand clinical care beyond the traditional office visits. Again, we want to get the healthcare out to where the veterans are in the veteran-facing. VA recognizes that mobile health is an emerging and essential element of healthcare and is dedicated to providing the up-to-date technologies to enhance these veteran experiences.

My HealtheVet is a portal that veterans use to schedule appointments, to fill prescriptions, review their healthcare records, and access their personal health information. In addition, on this portal, they have the ability to perform secure messaging. This allows the veterans at any point in the day, whenever it's convenient to them, to pose questions to their healthcare team, to email about experiences they're having or give

updates to their providers or nurses. They can also receive health educational material through this secure messaging.

We also have SCAN-ECHO. This is an acronym that stands for Specialty Care Access Network-Extension for Community Healthcare Outcomes. SCAN-ECHO uses dedicated video teleconferencing to simultaneously link several primary care providers, many of whom are in the rural areas, with those specialists that are in that same service area. The goals of this technology are to leverage telehealth to allow specialists from tertiary medical centers to support providers in less-complex or rural areas.

We have found that it decreases the cost of veteran travel and the necessity for veteran travel to a facility for care. It improves access to specialty care. It improves veteran and provider satisfaction, and it increases provider knowledge, competencies, and professional training in those rural areas or

where specialty services are not available.

VA now has an app store. You will find access to dozens of apps, including those created specifically for veterans and their healthcare professionals. You can download an app on imaging. You can download an app that assists you in managing your chronic conditions. But this is a whole app store now that we have for some of our veterans that really enjoy being able to manage their care via their own personal devices.

And finally, we have VA Point of Service Kiosks. That link allows veterans to check in for their appointments as they come into their clinic. They review and update their addresses, phone numbers, and email addresses. They can update their own next of kin, their insurance information, their copay information, and they can review their prescriptions and allergy information before they go in to meet with their provider. They can also view and print upcoming appointments.

So, we have quite an array of technologies that we're using to connect with our veterans at a point that's convenient to them.

So, finally, I'd like to thank you for agreeing to serve on this Commission and for the work that you are about to embark on. We know that we, as an agency, will benefit and, most importantly, our veterans will benefit from the work that you all will do.

Thank you so much.

(Applause.)

CHAIR LEINENKUGEL: Any questions of Beth at this point?

DR. KHAN: Jamil Khan.

CHAIR LEINENKUGEL: Jamil, use the mic, please.

DR. KHAN: My question pertains to the pharmacy. At present, I get 14 medications mailed to me, and sometimes they come in 14 different packages. Each package has large documentation attached to it. I've been taking those medications for the last 15 to 20 years.

Why cannot we stop the additional paper that comes with it? And it's too expensive to send 14 packages that can be mailed in one package. My recommendation is we should use the Pridecare model and save this extra money being wasted by the VA.

Thank you.

DR. TAYLOR: Thank you so much. Thank you for that comment. We'll take that back.

CHAIR LEINENKUGEL: It's a good opportunity because we're talking about streamlining and modernization. So, I mean, that fits right into Jamil's question.

Anybody else at this point? Because I have a comment and then a question or two that I think are pertinent. Let me start with the comment. This is something that I think -- Beth, thank you very much for presenting this -- this is just good background information that we all need to have access to, because this is the transformation to the new VA right

now, is the way I look at it. These are the things that have to happen and be implemented in order for us to move from World War II type of veterans service and care to the new future, as we like to term it. And this is really just starting.

You said something, Beth, about REACH VET, unless I did not pick that up right. But it was when you were talking about the predictive modeling of potential suicide. Was I correct in REACH VET? And can you explain a little bit more about REACH VET or what it is and what stage it's in right now?

DR. TAYLOR: Thank you for that question.

It's in a relatively early stage. And some of the folks with Mental Health, you know, from the Mental Health Service may be able to speak more in more detail to this. But it is a predictive modeling.

Suicide is very complex, and a lot of patients that report that they are not

suicidal do, indeed, commit suicide. We know that there are a lot of life events that are linked to suicide, to veterans committing suicide. It may be the loss of a spouse. It may be the loss of a job. It may be financial crisis.

So, how do we use the predictive modeling tools to look at the entire veteran's healthcare and see if we can predict, whether they say they're suicidal or not, whether we can predict people that are at greater risk for suicide? So, it is in a fairly early stage of development.

Anything, Wendy, you might add to that?

DR. TENHULA: I would just add, going with the idea that suicide is always multifactorial, and, oftentimes, I think the majority -- I don't remember the exact numbers, but can get them for you -- the majority of individuals, veterans who die by suicide who are in our healthcare system didn't endorse

suicidality at their last doctor's visit, were not identified as high risk for suicide based on clinical factors.

And so, we knew we needed to look beyond that and look broadly. And so, we took a huge database looking at veterans who had been suicidal and had died by suicide, and used that to develop, to look at which risk factors go into or which factors go into increasing someone's risk, and could we be more proactive about identifying those veterans who are at risk? And if we identify them at risk, be proactive about reaching out to them and intervening, and helping connect them with care, if they need care, but haven't yet sought care, or help them determine if there are other factors that are impacting their lives. Can we jump in and help with services in those arenas as well?

As Dr. Taylor said, it's in relatively early implementation stages. We're evaluating the effectiveness of it as we go and

have some early results that I think we could get for you, as far as looking at the effectiveness of the program.

CHAIR LEINENKUGEL: Thank you very much.

I have a request, and I'm going to drive people crazy with this screen, because I'm going to ask to go back to Beth's slide. I would like us all to take a look at slide 9, I think it was. I should have stopped you at that time, Beth, but you were on a roll. So, I didn't want to break it.

Let's see if that's the right slide.

DR. TAYLOR: The core health services?

CHAIR LEINENKUGEL: Yes. It is. In the headline there is something that I jotted down. Go back to the headline. Because I think it's going to be, it is relevant for this Commission.

The VA ensures that all eligible veterans have access to all the healthcare

services necessary to promote, preserve, and restore their health. And to me, it was -- Matt and I were walking over for lunch, and I think, Matt, this sort of hit home on the statements that we were bantering back and forth.

We need to have outcomes for our veterans to get better. That's the key success that we owe our veterans. If they are damaged, ill, sick, wounded, scarred, how do we get to promote, preserve, and restore their health?

So, I only bring that up as I'm editorializing, I think, a statement that we should use as a charge at some point for all of us to reflect going forward, seeing this is meeting No. 1 for us. I think that's critical for us to remember, especially under mental health, which we are certainly gauged to tackle here.

We really need to get to, are we restoring them for being productive citizens or productive soldiers once again? So, I think I

just like that headline, and I wanted to bring that to everybody's attention.

I know I'm taking up some time here, but I wanted everybody to have a little bit of clarity to your connected health, because it's going to blend into things where we're going. And again, it's so great to see, and I've been able to sit in for 18 months now, and there's been great progress made on telehealth.

I saw tele-mental health used for the first time, I want the Commission to know, in my hometown of 15,000 people with a little CBOC in Chippewa Falls, Wisconsin connected to a psychiatrist in Minneapolis. And the three veterans that had appointments that day were all under the age of 40, and that surprised me that they were willing to do, in a private, little room, that they felt comfortable with it.

And I was given permission to talk to one of them because he agreed. And he said it's made a world of difference. But the first

step that he had to have was a connection with a real person. And I wondered, is that the way it is with everybody that is going through some sort of struggles? And he said there was a definite connection with four visits -- and I think this is key -- with the same doctor, where he felt comfortable in getting into a booth and looking through a screen, talking with that doctor.

But it was the "aha" moment for me, that there's two things here. Can we get to that comfort level, that touchpoint where they feel they've made progress or a connection, as I call it, a true connection? And then, can we do this on an expanded basis in the rural communities, which I think there are some great needs? Whether it's in Arizona, Montana, northern Wisconsin, or Alaska, they're all rural. But we miss so many veterans.

My last point. You have a veteran population -- we talked about it briefly this morning -- but we need to, as a Commission,

have clarification because you brought up something important. There's 9 million enrolled veterans in VA care right now. When you say "uniques," the 6.2 uniques, those are the ones that you is as the VA services, am I correct in that, Beth?

DR. TAYLOR: Correct.

CHAIR LEINENKUGEL: So, there's 2.8 that are either getting their care elsewhere or not getting care.

DR. TAYLOR: Yes.

CHAIR LEINENKUGEL: But do we know if they're getting care or need care?

DR. TAYLOR: I don't think for all of them we know.

CHAIR LEINENKUGEL: Yes, that's probably the right answer. And it bothers us, I think, as commissioners, that we have that subset that we don't know. And I'm talking about mental health. And then, we have a whole 15 million others that we don't know.

And part of this Commission, as we

all know now, is we are tasked for trying to find out, if we can, just about every single one of them. Are they at risk? Do they have mental health needs?

And so, I think just from the VA's standard -- and I would talk to the Secretary about this -- because we struggled for 18 months, when I was actively involved, in getting clear numbers and knowing for certain within plus or minus 1 percent of our veteran population, of what type of care they're getting.

And I know there's a lot of new technology. You've listed it. And it's going to make a difference. It will take some time.

There's also this Medallia application, I believe, that Lynda Davis' group is bringing in that the commissioners should be aware of. And I think at some point Lynda's coming in, or somebody, to talk about that, yes.

So, it's important, and I'm saying

all of this because there's been great strides made. That's No. 1. But No. 2 is we still have gaps, and we're going to be asking from this Commission -- my guess is these commissioners are going to be saying, "Let's narrow the gaps."

DR. TAYLOR: We still have work to do, yes, sir.

DR. JONAS: So, let me just build on that with a couple of specific questions. I understand there's a new EHR joint DoD/VA electronic health record that's supposed to come out next year, is that correct?

DR. TAYLOR: Yes. There is a group that is working on that. I know that my boss has a meeting coming up, I think in two weeks, where they're going to spend the entire week talking with Cerner and talking about the EHR.

DR. JONAS: Yes, it's a Cerner-based thing.

Are we going to see some of that? Because that sort of is kind of important for

projecting into the future of how things are managed. I know in the civilian sector it's built around can we get payment, not around patient-centeredness. We know that. The question is, how is this one built?

So, a related question really is, is there a model? The very first task we were asked to do is to evaluate the efficacy of the evidence-based therapy model. And is there a VA therapy model? I mean, the predictive model is one you just mentioned for suicide. Most chronic disease, to my knowledge, is complex and multifactorial. So, it requires some kind of predictive components of it, if it is really going to be managed in the way that you've just described up there, Jake.

And so, you mentioned several times a hub-and-spoke model. That's another model. Is that changing? Are we still maintaining that in the VA? Are we going to a network model? What is the model? And are we going to find out about that?

DR. TAYLOR: Well, I think the short answer is you're probably going to learn more about that over the successive presentations. But I think it also depends on some of the specific programs. The hub-and-spoke model for some of our super-specialized programs, like spinal cord injury and disease like blind rehab, really do work. The folks for blind rehab actually fly into places like Tucson from Salt Lake, from Albuquerque, New Mexico, and spend a few weeks there and get the resources they need, the prosthetic devices they need, and then, go back.

I think the predictive modeling, though, for issues such as suicide is a very important model that we need to work on.

And I don't know, Wendy, if you have any other comments on the modeling specific to mental health services that may be of value to answer the question.

DR. TENHULA: I would agree that probably you're going to learn more there. To

my mind, the model we use needs to be tailored to the individual needs of the veteran, of each veteran. So, how we approach their care, whether it's through a hub-and-spoke model of telehealth or a hub-and-spoke model of blind rehab, will depend on what the individual needs of the veteran are. And I'll talk when I talk a little bit more about some of the approaches we use in mental health, too, that may help start giving you some information that will be helpful.

DR. BEEMAN: Dr. Taylor, I know you're not a health economist, but do you how much money the VA is spending on mental health services versus other things? It's my contention that in the civilian sector we underspend. In fact, the insurance companies are set up to minimize the access of patients. And the question I have, how much are we spending vis-a-vis the civilian sector? Two, is that enough? And three, are there other things that we're doing that we don't need to

do that we could stop, so that we could fund properly the mental health services that we want to provide?

DR. TAYLOR: Thank you.

I think that ties in with the VA priority of focusing our resources to be most effective and focusing in our resources on those things that are going to be most important for us to address with our veterans.

In terms of the actual cost, I don't have that data for you, but it's something that I believe that we can get for this Commission, if you're interested in such. So, I've made a note of it here and would be happy to bring back that information to your group.

Thank you so much for the question.

CHAIR LEINENKUGEL: Anybody else on the Commission with questions at this time?

Jack?

MR. ROSE: Yes. Just a question with respect to mental health. We've had the question about how much funding is coming at

mental health. The area of research which is so critical in mental health, what percentage of research right now is being directed towards mental health and improving it?

Thank you.

DR. TENHULA: That's a great question that we could get for you. I don't know.

I haven't been introduced yet, but I'm Wendy Tenhula from the Office of Mental Health and Suicide Prevention. We work very closely with our Office of Research and Development to help establish the research priorities when it comes to mental health.

It is, I can say, having been in the VA system for quite a while, it is a much larger percentage than it used to be, and there is a strong investment in VA research in mental health and in suicide prevention. And we can get you, absolutely can get you more information on that and more details on the priority.

And I hope that you all will be hearing in more detail over the course of your work about VA's research. Dr. Taylor mentioned VA's research efforts, and in mental health it's been so critical to innovations and changes.

MR. ROSE: Thank you very much.

And another thing, with the different programs that are going on, I think the Commission here will also be interested in the timelines that we're dealing with. You know, it's one thing to say that it's in our top priority, but what is the actual time right now that we expect to achieve those priorities? Okay?

Thank you.

CHAIR LEINENKUGEL: Thank you so much. It's nice having you with us today.

DR. TAYLOR: Thank you.

CHAIR LEINENKUGEL: We'll probably have you back or we'll come and see you at some point in time.

DR. TAYLOR: I'd love it. I'd love it. Thank you.

CHAIR LEINENKUGEL: At least as a subgroup.

And I have the opportunity to present Wendy, who's already commented a few times during this meeting.

Wendy, I'm trying to find your sheet here. So, I'll get to it. Oh, no, I've got it. We're all getting used to these binders, okay, for the first time.

(Laughter.)

CHAIR LEINENKUGEL: I have the privilege to introduce Dr. Wendy Tenhula. Dr. Tenhula is the Director of Innovation and Collaboration in the Office of Mental Health and Suicide Prevention at the VA. She oversees our Mental Health Centers of Excellence, including the National Center for Post-Traumatic Stress Disorder and programs that address women's mental health; also, families and the effects of military sexual trauma. She

also leads coordination with the United States Department of Defense and the Substance Abuse and Mental Health Services Administration on mental health issues and oversees the VA's national award-winning Make the Connection Outreach Campaign.

As a clinical psychologist, Dr. Tenhula has extensive expertise in psychological interventions, the cognitive effects of schizophrenia, vocational rehabilitation, and campaigns to reduce the stigma associated with seeking mental health treatment. Her research has been published in multiple articles and books.

She's earned her bachelor's degree in psychology at Vanderbilt University and a doctor of clinical psychology at Northwestern University. She's completed her internship and a postdoctoral fellowship at the Hennepin County Medical Center in Minneapolis, and second fellowship year in the Department of Psychiatry and Behavioral Sciences at Stanford

University School of Medicine. She has been with the Department of Veterans Affairs now for 18 years.

Dr. Tenhula, thank you so much for being with us today.

DR. TENHULA: Thank you. Thank you. Sorry, I'm trying to be practical before I even get started. How long should I plan on? I know we didn't get started on time. I don't want to take --

CHAIR LEINENKUGEL: We're fresh right now. This group needs to hear from you, Dr. Tenhula.

DR. TENHULA: Okay. Okay.

CHAIR LEINENKUGEL: So, I will be the judge if you're starting to go a little long.

DR. TENHULA: Okay. Give me the hook whenever you're ready to give me the hook.

CHAIR LEINENKUGEL: I will be the hook, yes.

(Laughter.)

DR. TENHULA: Thank you. Thanks, Mr. Leinenkugel, and thank you to each of you for agreeing to serve on this Commission. It's really important work and I appreciate the opportunity.

Dr. Taylor said she was going to talk at about 100,000 feet. I'll probably take you down to like 45,000 feet maybe on mental health.

And then, I know that at your next meeting you already have on the agenda Dr. David Carroll to go into even more depth on VA's mental healthcare. So, think of this as just an appetizer, a high-level sort of overview.

It really is a pleasure to be here. I'm honored to work in VA mental health, as Mr. Leinenkugel said, for the last 18 years in VA and various aspects of our mental healthcare system. Our office, the Office of Mental Health and Suicide Prevention, stands ready to help this Commission do their work, whether

it's providing follow-up information for your questions, providing documents, reports, any work that we've done that we can share to help you all as you are doing your work. We are standing by ready to help.

Can I have the clicker? That's good. There we go. Okay.

So, this is what I want to touch on. Like I said, you'll hear more in-depth from Dr. Carroll at the August meeting and have additional discussion, and I'll be happy to take your questions back to him, so that he can be even more prepared to answer them when he comes.

I'll give you a high-level, sort of general overview, a snapshot of VA mental health. I wanted to try to highlight a few areas where I think there are some unique aspects to VA's mental healthcare system versus the private sector mental healthcare system, and that I thought would be of interest to you as you're sort of launching into your work.

So, I'll touch on each of the areas here on this list, and I hope that will give you sort of a flavor of VA mental health services and some of the things we do, and some of the things we do that are unique.

VA provides a full continuum of mental healthcare from outpatient to residential and inpatient mental health services. They are recovery-oriented, going back to that idea of living the fullest life that you can live and the fullest life in ways that you want to live it. Veteran-centered and evidence-based. So, there's a lot packed into that phrase, all of which I think is really important.

As part of that full continuum of care, we have immediate crisis intervention and support available 24/7, 365 days a year, through the Veterans Crisis Line. And that's available by phone, online through the computer, and by texting on your mobile phone, across the healthcare system in different

setting.

So, we don't just think about mental health if someone comes to a mental health clinic. We proactively screen for depression and post-traumatic stress disorder and problematic alcohol use in primary care and across our health system.

Dr. Taylor touched a little bit on some of the connected care and uses of technology specific to mental health. We have several web and mobile tools that help connect veterans and their families to mental health resources. I'll talk a little bit about at least one of those later, but there's more; there's a lot there.

And one thing I want to mention that's unique to VA is the use of peer specialist. We have about 11000 peer specialists working in our system right now that really provide unique opportunities to engage veterans in care. So, our peer specialists are veterans themselves who have

themselves experienced mental health challenges and really are wonderful assets to our system. In fact, the mission that Dr. Taylor mentioned offers us the opportunity to expand the use of peer specialists, not just in mental health clinics, but in primary care clinics as well. So, we're excited about that.

I will also, just going back to one of Dr. Taylor's slides, note that, of the 11 foundational services listed on that one slide, four of them are specifically related to mental health. And I'll show you, too, a little bit about what percentage of our care is mental healthcare, but specifically in our foundational services. Military sexual trauma and related care, post-traumatic stress disorder, readjustment counseling, and substance use disorder care, all sort of fall within our mental health realm. So, obviously, it's a big part of what we do. The short way of saying what I'm trying to say is that mental health is a big part of what we do in our VA

healthcare system.

Along those lines, we have seen demand for VA health services go up. In fiscal year 2017, VA provided mental health treatment to more than 1.7 million veterans, and that increased by 80 percent from FY 2006 to FY 2017. And that's an increase that's more than three times the increase that we've seen across all of VA care. So, we're seeing more of an increase in demand for mental healthcare than we are -- we are seeing an overall increase in demand for VA healthcare. We're seeing more of an increase for mental health.

And just another way of saying that is, back in 2006, about 20 percent of people who came to VA for their healthcare were receiving mental health services, and last year that was about 28 percent. So, I think, Dr. Beeman, that goes back to your question a little about how much of the care we are providing is mental healthcare. It's a pretty big chunk of what we're doing.

I'm pushing the wrong button. I'm going to push my microphone button instead of my slide button.

The next thing I just want to touch on, again going back to what Dr. Taylor was saying about access to care, VA has undertaken extensive efforts to improve access to mental healthcare. And that includes access initially. So, when someone realizes that they might need mental healthcare and they want to get in to see somebody for that first appointment, but also we have to think about sustained access to care. So, can someone get a full course of, if what they need is psychotherapy, can they not just get in the door for their first appointment, but can they get in the door for weekly appointments for the period of time that they need that care? And so, we need to think about sort of the whole access picture.

I just want to highlight a couple of things in the access realm. Also, we

intentionally put access to high-quality care because we don't want to just provide access. If we can get someone in the door for an appointment, it's important that we get them in the door for an appointment for good-quality care that's going to be effective and helpful for them, not just that we can check a box and say we got them in for an appointment, right?

And so, a couple of things to point out. By the end of 2016, all VA medical centers attested to being able to provide same-day access for mental healthcare. So, if someone comes in and they have an urgent mental health need, they will receive immediate, same-day attention from a healthcare professional at that medical center or the CBOC, the Community-Based Outpatient Clinic, that they present to.

And I will also talk about a little bit more one of the ways that we have improved access to mental healthcare is through integrating mental health providers into our primary care settings. And open access is a

key principle of primary care-mental health integration. That is, if someone is there seeing their primary care physician, and the primary care physician identifies a mental health need, being able to do a warm handoff right away to a mental health provider is part of the model of primary care-mental health integration that is, I think, unique to VA's integrated sort of full continuum of care, being part of the system like we are. So, I wanted to mention that.

Two other quick things to highlight is expanding access to those with other than honorable discharges and the recent Executive Order, signed by the President in January, that enhances access for service members who are transitioning from active duty. Those are two populations that we know are in various ways at risk for adverse outcomes, and we want to make sure that we are paying attention to their needs and providing services as appropriate. So, those are two specific populations that we

have been focusing on in terms of access to care.

Sort of continuing thinking about access to high-quality care, and thinking about how do we know what the quality is, we have a number of different -- and I wanted to include this specifically because I think you all might be interested in some of the data from these sources. Again, as part of being an integrated system, we are able to tap into a huge amount of data and use that data for quality improvement.

So, we have the Strategic Analytics for Improvement and Learning, or SAIL. And the mental health SAIL domain has three components to it: an experience of care -- so, when a veteran comes to VA for mental healthcare, what is their experience of care like and how do we measure that? -- population coverage and continuity of care. So, those are the three sort of subdomains that we look at under SAIL that are related to mental health.

The Veterans' Outcomes Assessment is a phone interview -- going back to your point, Mr. Leinenkugel, about outcomes -- looking at outcomes for individuals who are new to mental healthcare. So, when they initiate mental healthcare, we follow up with them within two weeks after their initial appointment, and then, three months later. And we're looking at mental health outcomes, symptoms and functioning and how are they doing, and whether they've continued. And then, we can crosswalk that with our administrative data and look at their utilization of care, et cetera. So, that's the Veterans' Outcome Assessment.

The Veteran Satisfaction Survey is more geared towards understanding veterans' experiences of recent mental healthcare, not necessarily when they're just brand-new to care, but across the time that they receive care.

And then, we also have an Annual Mental Health Provider Survey where we look at

the experience of the mental health professionals that are working in the VA system.

So, those are some sources of data that we use for continuous quality improvement in our VA mental healthcare system.

I also just want to mention, in terms of ensuring that we're offering high-quality care, we have -- and I mentioned this a little bit already -- specialized programs to address the needs of specific populations, some of which are listed here. We offer training in evidence-based treatments for mental healthcare. As of a couple of months ago, more than 12,700 VA mental health clinicians had been trained in evidence-based psychotherapies, with about 8500 of that in either prolonged exposure or cognitive processing therapy, which are the two treatments for post-traumatic stress disorder that have the strongest evidence base. So, we are really investing in our mental health professionals and their

training, and making sure that what they can offer to veterans is based on the best evidence that we have.

We have implemented team-based mental healthcare, which really promotes veteran-centered care. It allows us to better coordinate care. It allows teams, interdisciplinary teams, to communicate better with each other. We have found that it improves veterans' engagement in care and also improves things for our staff, like job satisfaction and engagement and communication, as well as increasing access to care.

I also want to mention our Mental Health Centers of Excellence. We have 10 MIRECCs they're called, Mental Illness Research Education and Clinical Centers, and six or seven, depending on how you count, other Centers of Excellence in the realm of mental health. They each have a specific and distinct mission. Each of those 16 centers has a specific and distinct mission and are really

hubs of innovation for our system. They all have a combined mission of doing research, providing education, and developing innovative clinical programs, and testing innovative clinical programs. And so, they are a real, I think, jewel in our crown of VA does when it comes to mental health.

I work closely with them, and I know you guys have already reached out to a couple, the support staff have already reached out to a couple of our centers and gathered some information. So, they are a wealth of information, and I'm sure will continue to be so for your work.

I also want to mention -- it's not just us tooting our own horns -- external reviews of VA's mental healthcare generally find that VA care is equal to or better than care that's available in the community. And I understand that you will be hearing more about the National Academy of Medicine evaluation, which is the most recent thing. So, I'm

thrilled that you're going to be hearing more about that in detail. So, I won't go into detail here, but I think it's always helpful, not just for us to look at ourselves, look at what we're doing, but what do other people think of what we're doing?

All right. And so, I promised I would highlight just a few things that I think are more specific, but I think relevant to your work and unique to VA. One is the primary care-mental health integration. VA really is seen as a national leader in this area. What that means, as I mentioned, is that we have mental health providers who are embedded in primary care settings. It allows us to proactively screen. It allows us to identify and address mental health concerns as early on as possible. It allows us to identify and address mental health concerns for people who might not to walk down the hall to the mental health clinic, but might talk to their primary care doctor.

We know that a lot of mental healthcare is provided in primary care, and it better equips our primary care providers to provide that care. It reduces wait times. As I mentioned, one of the principles of our PC-MHI program is to have open access. And it gives us a doorway to engaging people who might need more extensive mental healthcare, to try to get them moving in that direction.

And I think it's important, going back to talking about suicide, to note that, according to the CDC, 54 percent of people who died by suicide did not have a known mental health condition. And about 40 percent of our own patients, veterans, who are seen in VA who died by suicide did not have a known mental health diagnosis or mental health treatment in the previous year, but they were being seen in VA. So, it's really important, I think, for us to make sure that our primary care providers are well-equipped to address the full range of challenges that veterans come to them with and

to try to help identify if someone is at risk, because a lot of people who are at risk are not being seen in mental health and don't have an identified mental health condition.

All right. I want to also just mention measurement-based care. That's an initiative that we've undertaken over the last couple of years whereby we use veterans' self-reported outcome measures to really individualize and improve mental healthcare. And it's very veteran-centered. It's evidence-based.

The idea is to collect, share, and act. That's our sort of quick and easy way to say it. We collect veterans' self-report measures, both at the beginning of treatment and, then, at regular intervals as part of their treatment. It gives us objective -- we use reliable, validated measures that are relevant to the type of difficulties a person is having.

We share those results with the

veteran. So, right there in the session, talk to them, show them, graph their progress, or lack of progress, and then, use that to make changes and make decisions about treatment and make decisions about when someone is ready to move on to less-intensive treatment, might need more intensive treatment, when a treatment is or isn't working. And it really allows us to empower veterans as partners in their care and use data and use information to provide the best care we can. So, it's an exciting initiative that we have underway.

I keep reaching for the mic button. I will turn off my mic at some point instead of advancing my slides. I need to put the microphone, the thing over here. Okay. Sorry.

So, just moving on, I want to just talk briefly about tele-mental health again, amplifying something that Dr. Taylor said about how much we have increased the use of tele-mental health in our system. In fiscal year 2017, we provided tele-mental health services

to more than 151,000 veterans, and that was more than 473,000 sessions.

Then, the red bar there shows the number of encounters or appointments, and the blue bar shows the number of patients, the number of veterans who received those services.

And the hub-and-spoke model is something we use for tele-mental health as well. We have tele-mental health providers that are located at one place, and they can work with patients who are at various places around the country, including telehealth to the home as well as to other VA locations.

Okay. I'm going to shift gears real quickly and mention our suicide prevention efforts. As we have talked about, this is a major priority for VA to address veteran suicide. We are taking a public health approach to veteran suicide. The idea is that suicide prevention is everybody's business. Suicide is preventable. And we know that the majority of veterans who have died by suicide

haven't come to VA, at least not recently, for care.

And so, we need to help reach veterans and their families wherever they are. We need to build community engagement. We need to change the conversation around suicide. We need to continue to develop innovative strategies for prevention and continue the work that we're doing within our VA healthcare system. Because we also know that, while the rates of suicide have been going up in our country overall, and rates for veterans have been going up overall, the rates for veterans who are in VA care are not going up as quickly as the rates for veterans who are not in VA care. They are still going up. It's still happening that there's an increase, but it's not going up as quickly for veterans who are in VA care. So, we need to do all these other things and we need to keep providing good mental healthcare and good care within our system as well.

Just to quickly mention some of the key suicide prevention goals that are directly in line with what I was just saying: the mobilized action nationwide; this idea that suicide prevention is everyone's business; expanding universal prevention initiatives. That means, in a public health model, universal prevention is a prevention strategy that's applied to everyone, not just those who are in specialty treatment and not just those who are identified at risk, but everyone.

Working closely with DoD and working closely on timely data reporting. We need to be able to see if change is happening. If we are making changes in our system, we need to be able to tell if that's making a difference.

Fostering innovation. Again, a public health research strategy. Educating veteran communities about lethal means safety, and going back to the idea of access to proactive mental health support and treatment, and with a particular focus with partners in

the community on veterans transitioning from service. So, those are some of the key focus areas or key holes related to our suicide prevention efforts.

I mentioned before the Veterans Crisis Line is available 24/7. The Veterans Crisis Line gets about 2,000 calls a day and, from a call, can initiate, can make a referral to -- at every VA medical center there are Suicide Prevention Coordinators, and the Veterans Crisis Line can link someone with the Suicide Prevention Coordinator to get them linked into care, and in an emergency situation, can initiate what we call a rescue, or can contact law enforcement and have someone immediately go to the person and try to intervene right away. So, I just wanted to mention that.

And then, the last thing I'll mention, we've talked a little bit about how we need to reach all veterans and how many veterans are not in our care. One way in which

we've worked on doing this within the mental health realm is through outreach.

The Make the Connection Campaign is VA's mental health public awareness and outreach campaign intended to connect veterans and their friends and family with information -- with each other, first and foremost -- with information and resources and help them identify, if they need help, how can they get in for help. We realize that there is still a stigma that veterans and their families associate with seeking mental healthcare.

The Make the Connection Campaign really highlights the strengths of veterans that have sought support. It features veterans themselves telling their own stories of difficulties they've faced and what has helped them, and what they have done to have healthier and happier lives. They're really incredibly powerful and courageous stories, and it's an online resource. It's through social media. The last data that I looked at, the Make the

Connection website had had about 15 million visitors to the website. About 59 million of the videos had been viewed by visitors to the website.

Our Facebook page for Make the Connection was featured by Facebook as the fastest-growing government or military sector Facebook page, and it has over 3 million likes, I think is the right word. I'm totally technologically not savvy.

And the reach of the public service announcements and things like that, it just goes directly to what you were saying about needing to reach all veterans and encourage those who are having difficulty to help them understand that there are resources available, that there are effective treatments available, if they need treatment, and better understand how and where to reach out for support. So, I just wanted to mention that because I think it is relevant to some of the conversation.

And I think that was the last thing

that I wanted to mention. So, quick snapshot, 45,000 -- did I hit 45,000-ish feet?

(Laughter.)

CHAIR LEINENKUGEL: I'd say 30,000.

(Laughter.)

DR. TENHULA: Thirty? Okay. And have you any questions?

CHAIR LEINENKUGEL: We're going to have a quick questions for you.

DR. TENHULA: Great.

CHAIR LEINENKUGEL: And if I can, I'll start.

This is going to go Dr. Carroll, who will be coming in next month. But it will be on the record, and I don't expect you to have the answer because I have not heard the correct answer for 18 months. But we need to find out the answer because you have an integrated, connected healthcare system now within VA dealing with mental health along with primary care. And you have a name for it and an acronym.

And I know it does work in certain VAs because I've seen it where the primary care doctor made sure that a patient did not leave until she saw, due to a stress situation that she had, a mental healthcare provider, which was fantastic.

Three things. No. 1, what's the true number of clinicians that the VA currently has open? Whether it's doctors, nurses, PAs, it doesn't matter. What is the exact number by table of organization that are not currently filled?

No. 2 --

DR. TENHULA: I'm sorry, that are not currently filled? So, vacancies?

CHAIR LEINENKUGEL: Vacancies, correct.

DR. TENHULA: Okay.

CHAIR LEINENKUGEL: And I'm saying this for a reason.

Two, what are the mental health vacancies that are open, both on the clinician

and systemwide shortage?

And then, three, it should be from the VA leadership -- certainly Dr. Carroll, I would think, would come back with, what is the right number? Because the TO might not be the right number.

So, I would that, by next month, we would be able to have some clarity for that. Because I can't imagine how you have a great primary care-mental health integration if you have 30,000 shortages, as have been bantered around in the press and on the Hill for the last 18 months, without the VA properly responding.

So, it's on record now for us to find out and get the exact number through this Commission, so that we have clarity going forward to see if there is a true gap and how we are going to resource that gap or repurpose dollars from other programs, as Commissioner Beeman brought up earlier. So, I think these are the right type of things that we, as a

Commission, need to start asking the questions and getting the answers to, so that we can come up with the proper recommendations.

But both of your presentations were absolutely spot-on from the 100,000-foot, 80,000, down to 35,000. And we're going to get down to ground level. That's where the Commission needs to be.

So, next? Wayne, did you have something?

DR. JONAS: Yes, I just wanted, actually, to add onto that a bit. I think it's in the same theme. I mean, just simple math. If 80 percent, or three times the service demand has gone up since 1006, as have the resources, given that you have such a good system -- it sounds like you have one of the top mental health systems anywhere -- have those resources gone up proportionately? So, was it one-to-one during that period of time? Or is there a relative deficit now? That's just building on your question here.

DR. TENHULA: So, I can say -- and we can provide more -- I don't have the exact numbers off the top of my head. I can say that mental health staffing during that time has gone up. So, I showed you the demand curve of how many more patients we're seeing and how many more visits. Mental health staffing has gone up during that period, but it has not kept pace.

DR. JONAS: It has not kept up?

DR. TENHULA: It has not gone up one-for-one with how much demand there's been.

DR. JONAS: So, there is a relative deficit?

DR. TENHULA: So, there is a relative --

DR. JONAS: Yes.

DR. TENHULA: It has not gone up at the same rate.

DR. JONAS: It doesn't match, right.

DR. TENHULA: The staffing has not, but it has gone up.

DR. JONAS: Have you evaluated the peer-to-peer system? I mean, is there some hard data on how that's impacted quality, access, outreach, mental health, any of the other outcome parameters in some way?

That's a model, by the way.

DR. TENHULA: Yes.

DR. JONAS: I'm interesting in models, as you know.

DR. TENHULA: That is a model. That is one of the models.

There is good evidence to suggest that it does improve engagement and does improve satisfaction with care. And we are in the process of evaluating some of the components of the peer specialist program, but haven't done a comprehensive evaluation.

DR. JONAS: Yes. Okay. My last question is, given that you have such a robust mental healthcare system and there is a movement now to try to increase the access into civilian populations, which I presume many of

which will not be as good, is there a problem there? For example, is there a need to kind of map out and create some top examples of what needs to happen if civilian groups get in?

Many of the mental healthcare is very similar to what goes on in community health centers. And you, having been at one of the best civilian community health centers, Hennepin County, how does that compare to that?

DR. TENHULA: It was an amazing experience.

DR. JONAS: Yes.

DR. TENHULA: You're right.

So, we've tried to address that. I'm not sure this will fully answer your question. But one of the things that we've tried to do, for example, is create training and education that is available for free and provide free continuing education credits for civilian providers on topics such as military culture competence, military culture training, on various aspects of suicide prevention that

are evidence-based.

And so, we've tried to do what we can to make it possible or make it easy for civilian providers to learn as much as they can, if they are going to serve our veteran population. So, it's not a complete answer to your question, but --

DR. JONAS: What I'm trying to get at, is the quality going to go down as the access in the civilian goes up?

DR. TENHULA: I think it's something we need -- we need to be able to look at that for sure. That's a great question.

DR. KHAN: I would like to give you feedback. I don't want to hear another veteran committing suicide. So, one of the quickest solutions within the budget is provide those who are flagged with a push-button technology.

Evidence-based confirms that where the veteran was reached the last minute, there were a large number of successful prevention. And this push-button should not be answered by

a call center. It should be answered by a qualified clinician. It will save lives.

I mean, you know, as a veteran, my heart goes out for the individual who is so far gone. And you can spend millions of dollars for cosmetic changes. It's not going to give you results than the one I'm giving you.

When somebody falls down and says, "I need help," that individual who has so much hopeless -- let's say Jamil, and I'm standing on the San Francisco bridge to jump. But, if I have that technology, there's a point, a 1-percent chance that I may push it. And I hear your voice and you tell me, "Jamil, go ahead and jump, but wait five minutes." And you start talking to me. Last-minute changes have occurred in people's lives.

So, I want to go on the record asking the VA to invest into that technology. It is available now.

Thank you very much.

DR. BEEMAN: Dr. Tenhula, I

appreciated your presentation. Just a couple of comments.

I have heard it said that 70 percent of those patients presenting themselves at primary care physicians would benefit from mental health services. Clearly, you are seeing more of those patients. But, as we have embedded mental health providers in primary care practices, the number of referrals is just skyrocketing, which creates a tremendous demand on the mental health provider.

I applaud your efforts to train veterans and look at alternative kinds of providers, but I think that that's something we should be prepared to answer. And that is, from an educational standpoint, what do we have to do as a nation to assure that mental health, which is now getting much more of a viewing point, what do we have to do to make sure that we have the right kinds of providers and train the right kinds of providers?

This has got a long tail on it.

What worries me, as the private sector gets into the business as well, we're going to create a tremendous shortage. We may not be able in government to meet or compete for the professionals because they have more money to spend perhaps. How are we going to meet that demand? So, we have to be prepared, I think, to answer that question.

Thank you.

MR. ROSE: If I may, to follow up on that, too, and then, all at once, because I think out in the civilian sector there is a definite shortage in the mental health profession.

And I applaud the VA for having the wherewithal to do what you all do. But, as we start sharing between the VA and the civilian side, the civilian side is not necessarily going to be able to help us out because they're just not there. The resources aren't there.

DR. TENHULA: That's a good point and something that is really important to look

at and be mindful of. The shortage of mental health professionals, the gap demand, between need and professional services available isn't a problem that's unique to VA. It's our mental healthcare system in our country is lacking providers.

Thank you.

MR. ROSE: And if I may, just one more on your family program. I know I have done some work with the National Alliance on Mental Illness, and their family-to-family program has been fantastic. And I believe the VA is going along similar. Is that correct? It works?

DR. TENHULA: Yes. We have an agreement with NAMI to do the family-to-family education program at VA medical centers.

MR. ROSE: It works?

DR. TENHULA: Yes.

CHAIR LEINENKUGEL: I don't want you ruining Dr. Carroll's nice vacation in Germany and pinging him immediately with those three

requests from the Commission. But I bet you some staff members can start working on that for him.

DR. TENHULA: I promise that we will not bother him with it until after he returns from his vacation.

CHAIR LEINENKUGEL: Doctors, thank you both. It's been very beneficial for this Commission to have both of you onboard for our first public session today. And thank you for your time and your efforts with working with veterans in all cases. Thank you.

(Applause.)

CHAIR LEINENKUGEL: Because we got so frisky with the pertinent questions, we're about 30 minutes behind. So, what I'm going to do is make the chairman's statement that there will be no formal break. So, if you need a bio break, we're all educated and old enough to do that by ourselves. And we'll take notes if you're missing for a few minutes or if you have an emergency call. So, we're going to press

forward and move on to the next presentation.

We have three very prominent ladies in front of us, and I'm not going to read each of their bios because that would cut in another 10 or 12 minutes because they're extensive.

But I've gotten to know them and I know the quality of work they do. I have been able to participate in the things that I spoke to some of our commissioners about earlier this morning in our closed session, about Tracy Gaudet, and certainly Alison Whitehead is working with us as well, and also with working with Tracy and the team, and also could be at the ready. So, we're looking forward to this presentation, and the floor is now yours.

DR. GAUDET: Great. Thank you. We appreciate the skipped bios. We're happy to provide details --

CHAIR LEINENKUGEL: Well, they're awesome bios and we have all of them.

DR. GAUDET: Very happy to provide any details you want after the session.

I'm Tracy Gaudet. Very honored to meet all of you, and I'm very excited, we all are, about the Commission and the opportunity before us, the VA and the nation actually.

So, we want to talk to you all about the work we're doing in whole health, and I'll describe what that is. But I just wanted to tee that up by saying what I'm sure you already know. But we have such a tremendous opportunity right now to not only like kind of break through an old way of thinking about sickness and disease, and really get to optimal health and well-being, and do that not only for our veterans, and model it in the VA, but model it for the nation.

And I think your leadership and this Commission can help us do that. So, I just wanted to put that upfront and say we're thrilled and we are at your beck and call in any way, shape, or form across the 18 months, or whatever the timeline is, of your very important work.

I thought maybe we should do this or something, the three of us.

(Laughter.)

DR. GAUDET: But we're going to present to you. I want to start the vision. Because I left academic medicine, a long career in academic medicine, to join the VA because of the opportunity to really catapult VA healthcare in directions that the VA has the vision for.

And I'm not going to spend a lot of time, but I want to ground us in the fact of what we all know, which is our current healthcare paradigm is very broken. There is tremendous data on cost, on outcomes, you name it. You know, we spend so much more in this nation on healthcare, and we get very poor outcomes. We're 37th in life expectancy, as an example.

And everybody knows this is not sustainable. Everyone in the nation is calling for a massive transformation in how we think

about health. We know it's somehow related to helping people take charge of their health and well-being, because 75 percent of costs are due to chronic conditions that are affected by people's choices.

The problem -- and I should say I'm a physician; I'm trained as a physician, an obstetrician/gynecologist. I'm trained in the medical model. And the problem that we have is that the system of care we have is not actually designed to optimize people's health and well-being. It's not what the system is set up for. It's set up to really diagnose and treat disease, and that's important. We're not saying we should throw that out, by any stretch, but we're saying it is not adequate. And it's why we have these huge gaps that we have.

Can you be my like Vanna White and pass those out? Okay.

We've been working in the VA to say, how could we do healthcare in a completely

different way? And this I'm passing out because you can see this model in the first -- if you open up that little handout, you can see it a little bit better than on this slide.

And we have been working with this model -- we call it the whole health approach -- for many years now. We stood up our office in 2011.

And the characteristics at the bottom, the person at the center is really critical. And that comes from the understanding that, you know what, we start in healthcare with the person's chief complaint. We start with their problem. We don't start with who they are. And so, of course, they're not going to be engaged. So, we start with who you are.

Actually, it used to say "you" in that little center. And I was at the Fayetteville, North Carolina, VA, and there was a homeless veteran who was holding this thing up. And he said, "This put me back in my life

again." And I went, oh, why does it say "you"? It should say "me". So, it says "me" now.

The concept of mindful awareness is around the center of that. And I would like to say a word about that, and then, give you a 60-second experience.

The concept is, whether we're talking about the space between, as you so eloquently said, Dr. Kahn -- is it "Doctor"? I don't know everybody's official titles.

DR. KHAN: Jamil.

DR. GAUDET: Jamil. Thank you. The moment between the thought of jumping over the bridge and the action, if we just could put space between the thought and the action, just a moment, there's an opportunity to change the outcome, right?

So, the concept of mindful awareness is teaching veterans -- and veterans love this and get this -- just to take a moment and tune into the state, whether it's the state of their depression, whether it's the state of their

impulse to end their life, whether it's, oh, something practical like tuning into, oh, I have pain right now; it's at a level 2; I wasn't really noticing it because I don't usually pay attention until it's a 9. But, oh, if I pay attention now, I could be more proactive about my health and well-being.

So, that concept of mindfulness and awareness is a skill that we're teaching, and it interfaces with all of those areas of green. And all of the areas of green are self-care. It spans everything from relationships to work, to stress, to nutrition, to surroundings, et cetera. And all of those elements we know are so critical to someone's health and well-being. It's the majority of the model. And yet, our healthcare delivery system is actually focused only on the blue, on the professional care, right? So, how do we begin to shift that? It really requires that we change the conversation.

Two quick stories I wanted to tell

to demonstrate what this approach looks like. One is a story that Jeff Milligan, who is now a Network Director, told when he was the facility Director in Dallas. And he tells the story of a gentleman, a veteran, who was a patient, an outpatient veteran in their primary care clinic who committed suicide. And he tells it very eloquently and beautifully.

But he talks about learning about that gentleman and his life and his story. And what was surprising is that he was a diabetic. He was hypertensive. His blood pressure was great. His sugars were great. The primary care team was devastating. They thought they knew this gentleman well. They had no idea that he was suffering. They felt personally responsible and guilty.

And the reality is, they did everything right. They did everything right in our current system. You know, they asked all the questions they were supposed to ask. They checked all the boxes. But we're asking the

wrong questions and missing people's suffering.

So, one of the things, on the second page of that handout you will see we have these scales now that we're doing. I call them vitality signs, which are simply asking people to say, on a scale of 1 to 5, where 1 is miserable and 5 is great, how are you feeling mentally and emotionally? How are you feeling physically? How is it to live your life, miserable to great?

And if we were asking those questions, we would be finding suffering in places where we don't even know it exists right now because the system isn't set up to ask those things. And that's really, really important.

I'll give you one other illustration, how teaching people to change the conversation can change everything. And this is a story that a physician in Boston, Jackie Spencer, shared and gave us permission to share.

She was in a busy clinic, seeing her patients. An OEF-OIF veteran comes in who she had seen a couple of times before. She said, this big, burly guy, and he comes in and he's got knee pain. Chief complaint, knee pain.

And she said, "I'm doing my thing. I'm going down the list. I'm setting him up with his referrals for his knee pain." Then, she said, "I looked over at his whole health review systems," this thing. And she said, "I noticed when it came to his relationships and his sleep, he scored, like he self-assessed miserable."

She said, "So I stopped what I was doing and I said, `Hey, you know, I notice miserable on these areas.'" And she said he just broke down, and she said, "He cried like no one I had ever even seen cry before." And this gentleman was suffering with horrible PTSD and his whole life was falling apart. And she said, "I would have missed the whole thing because I was doing the knee pain." He came in

with knee pain.

So, there are a thousand illustrations of, as we're changing the conversation and we're teaching people to do that, and we're teaching veterans to do that, and clinicians to do that, everything can shift. And it's really quite powerful.

So, we went from saying, okay, this is the right construct, but how do we deliver this, right? Because the current system, like I said, is not set up to do this. So, being clinicians -- and I take full responsibility for this error -- we said, "We'll just shove into primary care," right? Because that's what we do.

So, we said, okay, we're going to focus on this treat bucket. And now, when people come to their visits, and primary care visits in particular, we're going to train clinicians in this approach and we're going to do all of this in the clinic.

So, you guys are looking at me like,

"Yeah, I can tell you that wouldn't work." Right?

(Laughter.)

I mean, it's not a bad concept, but there's too much to do in the clinic. So, the burden in the clinic got worse. We're like this is not working.

And then, I have to just tell you, really quickly, this one story. Because in the VA people like to mandate things. I am not a fan of mandating, but it's a common thing.

So, one of the networks says, oh, we're supposed to find out what people really -- what really matters to them in their life; we're changing the conversation.

So, he mandated -- do you know this story? -- he mandated that every veteran will be asked this question. So now, this mandate goes out, and there's clerks checking the veterans in for their appointments. "What really matters to you?"

(Laughter.)

DR. GAUDET: And the veteran is like, "What?"

So, you can see this doesn't work. So, we got a little -- not "we," our office -- the field. All of the innovation, all of the great stuff happens in the field. We just observe it, support it, remove the barriers, and help systemize it.

So, we said, ah, the field said, you know, let's co-create in parallel to the clinical entities well-being programs that are designed to equip people to take on these aspects of their well-being, because that doesn't even belong only in the clinic. And you'll hear in a minute how this is actually working.

And that was really an important breakthrough, that it wasn't just doing it differently in the clinic; it was actually reconfiguring what healthcare is and how we deliver it. And if, in addition to clinical care, we have well-being programs that are

focused on equipping people, that's a big deal. We're going to connect it with their personal health plan.

That's really working. It really works when veterans are already engaged. But the majority of us are not particularly engaged in our health and well-being unless we have an event that forces that.

So, we said, ah, there's a third part of this whole health system and it is the empower piece. It is, how do we help people explore what really matters to them in their life and actually link their health and their healthcare to that, right?

So now, what we're finding are amazing stories -- and I'm going to let Kavitha tell some of them -- of people discovering what they want to live for and doing that with peers, not with clinicians, doing that with family members, and really bringing that forward to this is what I want my health and life for. And now, they're empowering. Then,

they get the skills they need in the well-being programs and, then, they have clinical care that's aligned, too.

So, this is a really radical -- if I'm doing what I want to do effectively in these few minutes, it's to help communicate this is a radical redesign of what healthcare this. This is way different than the current dominant paradigm in American medicine, and the VA is putting this into action and leading the way.

And with that, I'm going to let Alison tell you practically what that looks like.

MS. WHITEHEAD: All right. Well, thank you for that nice setup.

So, I just wanted to mention, too, I think in the mail-outs you maybe received the entire CARA legislation, which is huge. Section 931, which is the COVER Commission, is one of those very important pieces.

And then, two other sections that